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Office of Administrative Law Judges
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Issue Date: 27 June 2007

In the Matter of:

K.G., Survivor of C.G.,
Claimant

Case No.: 2005-BLA-05422

v.

EASTERN COAL CORPORATION,
Employer

THE PITTSTON COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

James D. Holliday, Esq.
Hazard, Kentucky
For the Claimant

Lois Kitts, Esq.
Baird & Baird, PSC
Pikeville, Kentucky
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq.* The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C.

§ 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that she is the surviving dependent of a miner whose death was due to pneumoconiosis.

I conducted a hearing on this claim on December 6, 2006, in Pikeville, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director, OWCP, was not represented at the hearing. The Claimant was the only witness. Transcript ("Tr.") 14-21. Director's Exhibits ("DX") 3-34, Claimant's Exhibits ("CX") 1-5, and Employer's Exhibits ("EX") 1-11 were admitted into evidence without objection but subject to the limitations on medical evidence contained in the rules. Tr. 6, 8, 9, 11. The parties agreed that medical evidence from the Miner's claims during his lifetime should not be considered and, after discussion, the Miner's claims, DX 1 and 2, were excluded from the record. Tr. 11. The record was held open after the hearing to allow the parties to submit CX 5, EX 8, and EX 9, which were admitted provisionally subject to submission for the record after the hearing, and also for closing arguments. The Claimant submitted CX 5 (mismarked as CX 6), and the Employer submitted EX 8, but not EX 9. The Claimant and the Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence unless otherwise noted, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Miner submitted two claims during his lifetime. DX1, DX 2. As noted above, the Miner's claim files are not in evidence.

The Claimant filed her claim on September 26, 2001. DX 3. The claim was awarded by the District Director of the Office of Workers' Compensation Programs ("OWCP") on February 19, 2003. DX 24. The Employer appealed this decision and requested a hearing before the Office of Administrative Law Judges. DX 27. The claim was originally referred to the Office of Administrative Law Judges on May 29, 2003. DX 32. However, Administrative Law Judge Daniel F. Solomon remanded the case to the Director because part of the Director's file was missing. DX 33-28. After the Director provided the parties with the missing exhibits, the claim was referred back to the Office of Administrative Law Judges for hearing on January 6, 2005. DX 34.

APPLICABLE STANDARDS

This claim was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations. For this reason, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). A surviving spouse is entitled to benefits if the miner died due to pneumoconiosis which arose out of coal mine employment. *See* 30 U.S.C. § 901; 20 CFR §§ 718.205 and 725.212(a)(3) (2006). The claimant must first establish that the miner suffered from pneumoconiosis. *See Trumbo v. Reading Anthracite Co.,* 17 B.L.R. 1-85 (1993).

ISSUES

The issues contested by the Employer are:

1. Whether the Miner had pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether his death was due to pneumoconiosis.

4. Whether the Claimant is an eligible survivor of a miner.

DX 34; Tr. 5. The parties agreed that the Miner had 21 years of coal mine employment. Tr. 10.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified at the December 6, 2006, hearing, and was deposed by the Employer on March 5, 2002, DX 14. She was married to the Miner for 29 years. DX 4. The Claimant and the Miner had one child, who is not dependent upon any parental support. The Miner died on July 2, 2001. Since the Miner's death, the Claimant has not remarried. I find that the Claimant is an eligible survivor of the Miner.

According to the Claimant, the Miner had 21 years of coal mine employment with the Employer. He worked underground as a shuttle car operator and a pinner. She was able to recall that he was exposed to coal dust. The Miner quit working in the mines in 1992 due to a knee injury. His last coal mine employment was in Kentucky. DX 3; Tr. 5. Therefore, this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

In an Affidavit concerning the Deceased Miner's Condition, the Claimant stated that since 1992 the Miner experienced shortness of breath even while watching TV. He would gasp for air, wheeze, and cough. When he exerted himself, his symptoms would become worse until he had to stop and use an inhaler, several times a day. He was unable to garden, his favorite activity, or walk more than a slow pace, as anything more resulted in his being short of breath and having to use his inhalers. She stated that her husband worked as a roof bolter until he became disabled in 1992. DX 7.

The Claimant testified that the Miner was a light smoker and did not smoke at all when he fell ill.

The Miner's family physician was Dr. King, who treated the Miner for more than 10 years. Dr. King was treating him for a pulmonary condition. Additionally, the Miner was treated by Dr. Musgrave for approximately 3½ years. While working in the mines, the Miner suffered with breathing problems like shortness of breath. Prior to the Miner's death, he suffered with esophageal cancer, breathing problems, and fluid on the lungs.

Medical Evidence

Medical evidence from a miner's claim is not automatically admissible in the survivor's claim. The parties must specifically identify the medical evidence from the deceased miner's prior claims for admission and that evidence is subject to the limitations on medical evidence under 20 C.F.R. § 725.414. *Church v. Kentland-Elkhorn Coal Corp.*, BRB Nos. 04-0617 BLA and 04-0617 /BLA-A, ALJ No. 2003-BLA-5484, electronic slip op. (PDF) at 5 (BRB April 8, 2005). In this case, the Claimant and the Employer agreed that the medical evidence from the Miner's claim should not be considered, and the Miner's claim files, DX 1 and DX 2, were excluded from the record.

Biopsy

Biopsies may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2006). Section 718.106(a) provides that a biopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. The Benefits Review Board has held, however, that the quality standards are not mandatory and failure to comply with the standards goes only to the reliability and weight of the evidence. *Dillon v. Peabody Coal Co*., 11 B.L.R. 1-113, 1-114 (1988); *see Dagnan v. Black Diamond Coal Mining Co*., 994 F.2d 1536, 1540-1541 (11th Cir. 1992). Section 718.106(c) provides that "[a] negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis." A biopsy of the Miner's pleural lesions was taken on June 22, 2001, a little over a week before his death, in an attempt to identify the cause of his recurrent pleural effusions. There was no mention of pneumoconiosis in the biopsy report. DX 6.

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. X-ray interpretations submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records are not subject to the limitations.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment, are listed in the "silent" column.

Qualifications of physicians who read x-rays in connection with the black lung claim appear after their names. Qualifications are abbreviated as follows: B=NIOSH-certified B reader; BCR=Board-certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n.16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be Radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
04/21/92			DX 6 Halbert Normal chest
09/29/94			DX 6 Halbert Normal chest
07/16/98			DX 6 Poulos Normal chest
08/21/98	**CX 4 Alexander BCR/B ILO Classification 1/0**	**DX 33-6, EX 7 Wiot BCR/B**[1]	DX 6 Halbert Clear with exception of air fluid adjacent to the mediastinum
09/17/98			DX 6 Kendall No evidence of active infiltrate
10/09/98	**CX 2 Alexander BCR/B ILO Classification 1/0**	**DX 33-7 Wiot BCR/B**	DX 6 Halbert No evidence of active disease
12/29/98	**CX 3 Alexander BCR/B ILO Classification 1/0**	**DX 33-8 Wiot BCR/B**	DX 6 Poulos No active disease noted
04/15/99			DX 6 Halbert Increased amount of fluid; no active cardiopulmonary disease

[1] Dr. Wiot prepared a report dated November 30, 2005, regarding the August 21, 1998, x-ray, EX 8, in order to rehabilitate his finding after Dr. Alexander read the same x-ray as positive, CX 4. Dr. Wiot again opined that the x-ray demonstrated no evidence of coal worker's pneumoconiosis. He "totally" disagreed with Dr. Alexander's reading of the x-ray as positive, stating, "[t]here are absolutely no findings to suggest coal workers' pneumoconiosis."

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
11/30/99			DX 6 Halbert No evidence of active disease
12/31/99			DX 6 Kendall No evidence of acute infiltrate
10/03/00			DX 6 Kendall Lungs were clear DX 6 Poulos Stable postoperative changes, no active lesions in either lung
11/03/00			DX 6 Poulos Patchy area of infiltrate, no other abnormalities
04/03/01			DX 6 Kendall New right based atelectasis with small right-sided effusion
04/11/01			DX 6 Halbert Infiltrate observed on the right lung, left lung appears clear
04/16/01			DX 6 Poulos Decrease in right-sided effusion, status post thoracentesis, no acute disease.
05/16/01			DX 6 Halbert Increasing right infiltrate and effusion

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05/29/01			DX 6 Halbert Volume loss and infiltrate on right lung, left lung is clear
06/05/01	**CX 5 Alexander[2]** **BCR/B** **ILO Classification 1/0**	**DX 33-9, EX 7 Wiot[3]** **BCR/B**	DX 6 West Progressive right effusion
06/07/01			DX 6 West Progressive infiltrate and effusion on the right
06/11/01			DX 6 Halbert Decreased effusion with placement of right chest tube
06/12/01			DX 6 Poulos Diffuse infiltrate continues on right
06/16/01			DX 6 Halbert No change in pleural density on right
06/22/01			DX 6 Kendall Decrease in right-sided effusion with moderate size right mid and basilar infiltrate with small right effusion

[2] Dr. Alexander observed post-surgical changes in the first three x-rays he read. The June 5, 2001, x-ray showed a "7x3cm right hilar mass c/w lung cancer & right pleural effusion and right lower zone atelectasis or scarring; left subclavian chemotherapy infusion catheter."

[3] In his report dated May 27, 2004, DX 33-5, Dr. Wiot said that all four x-rays he reviewed showed previous surgery with resection of the esophagus and a gastric pull-through. There was no real change between August and December 29, 1998. The June 5, 2001, x-ray showed a portacath in place, and a right pleural effusion which was not a manifestation of coal dust exposure.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
06/23/01			DX 6 West Congestive heart failure DX 6 West Central vascular congestion suspected.
06/24/01			DX 6 West Resolution of vascular congestion
06/25/01			DX 6 Kendall Interval decrease in vascular congestion
06/26/01			DX 6 West Very mild central vascular congestion, no other active pathology.
06/27/01			DX 6 Kendall No change in bilateral effusions
06/28/01			DX 6 West Regressing pleural effusions
06/29/01			DX 6 Kendall Improved aeration in the lung bases
06/30/01			DX 6 Halbert Perihilar infiltrate on the right

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991).

The Miner had nine CT scans taken during his treatment for esophageal cancer. The Employer offered multiple rereadings of the CT scans into evidence. Because the CT scans were taken as part of the Miner's treatment, I find that the Employer was not entitled to submit any rereadings of the CT scans without a showing of good cause. *See Henley v. Cowing & Company, Inc.*, BRB No. 05-0788 BLA, slip op. at 4-5 (May 30, 2006) (unpub.) (suggesting that an x-ray reading which was part of the treatment records was not subject to rebuttal, and instructing the Administrative Law Judge on remand to reconsider admissibility of a rereading offered by the Employer which was admitted at the original hearing). As the Employer failed to show good cause for rebutting the treatment scans, I have not considered them. Moreover, if any rereadings were admissible, the Benefits Review Board held in *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-___ (BRB No. 05-0335 BLA) (Jan. 27, 2006) (*en banc*) that the parties are entitled to introduce only one reading of "other evidence" such as CT scans. Thus, only one rereading of each CT scan would have been considered. In any event, for the reasons stated below, I have found the CT scans from the Miner's treatment to be negative for pneumoconiosis. All of the Employer's rereadings were also negative. Moreover, one of the Employer's experts, Dr. Fino, did not reread the scans until after he had rendered his initial, negative opinion. Hence, exclusion of the Employer's experts' re-readings, and the fact that the Employer's experts considered them, makes little difference to the outcome of the case. The following table summarizes the results of the CT scans taken during the Miner's treatment.

Date of CT Scan	**Physician Impression**
07/16/98	DX 6 Poulos No parenchymal nodules or pleural abnormalities, nonspecific CT scan findings
08/21/98	DX 6 Halbert Post surgical changes, lungs are clear with "exception of air fluid level which is seen adjacent to the mediastinum"
08/04/99	DX 6 Halbert Post surgical changes
02/02/00	DX 6 Kendall Surgical changes without evidence of acute cardiopulmonary disease
02/19/00	DX 6 Halbert Lung fields clear, no pleural abnormalities
08/03/00	DX 6 West Lungs look clear
11/16/00	DX 6 Kendall Small area of atelectasis vs. infiltrate on the right
04/12/01	DX 6 Poulos Fluid in the right pleural space

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction or restriction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1), and maximum voluntary ventilation (MVV).

There is only one pulmonary function study in evidence in this claim. The following chart summarizes the results. Bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	**Age Height**	**FEV_1**	**FVC**	**FEV_1/**	**MVV**	**Qualify?**	**Physician Impression**
DX 6 at 165-168 12/12/00 Mettu	50 73.0"	2.31	3.23	72%	52	Yes	Moderate restrictive airway disease with decreased MVV. Lung volumes are consistent with restrictive disease. DLCO mildly decreased. Invalid per Dr. Fino, EX 1, and Dr. Rosenberg, EX 5.

Medical Opinions

Medical opinions are relevant to the issues of whether the Miner had pneumoconiosis and whether pneumoconiosis caused the Miner's death. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR

§ 718.202(a)(4) (2006). The cause of death must be proved by competent medical evidence. 20 CFR § 205(c) (2006). The record contains the following medical opinions relating to this claim.

Treatment Records

The file contains over 700 pages of treatment records from the Miner's treating physicians, Dr. Samuel J. King, Dr. Tamara L. Musgrave, and Dr. Anthony Rogers, and hospital records from Central Baptist Hospital and Pikeville Methodist Hospital. The Claims Examiner for the OWCP also requested medical records from Dr. R.V. Mettu. Dr. Mettu responded that all of the Miner's records were released to the Department of Labor in 1993, and there were no more examinations of the Miner thereafter. As noted above, the records from the Miner's claim were not admitted into evidence. All of the information contained in this summary of the Miner's treatment records can be found in DX 6.

The Miner had a kidney stone in 1979, with documented recurrences of kidney stones in 1986, 1990, 1998, and 2000.

The Miner was hospitalized from March 29-April 3, 1992, after an injury to his knee at work in the mines. He underwent arthroscopy of his knee on April 22, 1992, to repair a tear of the medial meniscus. According to the discharge report, he was smoking a pack of cigarettes per day.

Dr. King was the Miner's treating physician from 1993 to 2001. His credentials are not in the record, and he is not listed on the website of the American Board of Medical Specialties.[4] Dr. King's progress notes from 1993 to January 1997 were handwritten and are somewhat difficult to decipher. Thereafter, the notes were typed.

On July 22, 1993, the Miner saw Dr. King about his right knee which had been injured in 1992. Diagnoses included degenerative, post-traumatic osteoarthritis (OA) of the right knee and psoriasis. A third diagnosis is illegibly abbreviated. The same problem with his knee occasioned his next visits on April 18, May 2, and August 29, 1994.

The Miner underwent additional surgery on his knee on October 4, 1994, due to an extension of the meniscal tear.

The Miner returned to Dr. King for a checkup on November 28, 1994, at which time his diagnoses were gastroesophageal reflux disease (GERD), costochondritis, internal derangement of the right knee, and high blood pressure (HBP). His next visit on March 3, 1995, was again related to his knee.

The Miner was admitted overnight to the Central Baptist Hospital on April 4-5, 1995, complaining of chest pain and severe dyspnea on exertion. Noninvasive testing for ischemic heart disease was inconclusive. He was referred for diagnostic cardiac catheterization and coronary angiography. There was no evidence of significant structural or functional heart

[4] The website can be found at http://www.abms.org. The parties were notified at the hearing that I would take judicial notice of physician qualifications listed on the internet by this organization, and had no objection to my doing so. Tr. 10.

disease. The chest pain and dyspnea were of uncertain etiology. The Miner was urged to modify his risk factors, including ceasing use of tobacco products, weight loss, and regular exercise. He was advised to return to Dr. King for further workup of his dyspnea, which "likely is related to his known coal workers' pneumoconiosis."

Dr. King's notes from May 16, 1995, reflect the first reference to occasional dyspnea, and a diagnosis of chronic obstructive pulmonary disease (COPD) versus coal workers' pneumoconiosis (CWP), with a notation that the Miner was a nonsmoker. It appears that the Miner's chest was clear on examination. Dr. King's prescriptions included sample inhalers. The same diagnosis appears on the notes from the Miner's next visit on August 17, 1995. The Miner had a checkup on December 18, 1995. Diagnoses were GERD, HBP, osteoarthritis (OA), and COPD. He had an exacerbation of his COPD at a checkup on April 18, 1996. On August 19, 1996, the Miner complained of low back pain (LBP). Diagnoses were GERD, hypertension (HTN), OA, and COPD. At a check-up on December 19, 1996, he complained of an increase in his back pain.

The Miner returned to Dr. King on December 30, 1996, after suffering some soft tissue injuries in a motor vehicle accident which occasioned a visit to the emergency room on December 29, 1996. By January 16, 1997, the Miner was doing better, but the doctor planned to obtain an MRI of his knee. MRI showed post-surgical changes in the medial meniscus, a non-symptomatic tear of the lateral meniscus, and irregularity in the articular surfaces, which suggested that he had sustained a contusion to the knee superimposed on pre-existing degenerative changes noted on arthroscopy in 1994. Recommendations included a course of physical therapy and continuation of a brace and nonsteroidal medications. Dr. King saw the Miner for follow-up on his knee on April 17, 1997, and then continued with his general care thereafter. Visits on August 21, and December 22, 1997, contained no references to pulmonary symptoms other than the continued diagnosis of COPD. Chest examinations were always reported as clear. The December notes indicate that the Miner was a tobacco chewer.

On July 13, 1998, Dr. King reported that the Miner had been experiencing dysphagia for two or three weeks. Dr. King recommended esophagogastroduodenoscopy to evaluate him as he had not responded to medication.

Esophagogastroduodenoscopy with biopsy on July 16, 1998, revealed an obstructing mass in the esophagus which was consistent with carcinoma, confirmed on biopsy. The Miner was hospitalized from July 17, to August 2, 1998. On admission, he reported difficulty swallowing and a 40-lb. weight loss over the last few months. The Miner underwent esophagogastrectomy with abdominal thoracotomy on July 21. He did well post-operatively, and was discharged on August 2, 1998, with a discharge diagnosis of adenocarcinoma of the esophagogastric junction.

Dr. Rogers, the Miner's surgeon, who is Board certified in Surgery and Thoracic Surgery, saw him for follow-up from his surgery on August 6, 1998. His lungs were clear, and Dr. Rogers said he was doing "excellent."

Dr. Musgrave was the Miner's oncologist who followed him after his initial diagnosis and surgery for esophageal cancer. According to the website of the American Board of Medical Specialties, Dr. Musgrave is Board certified in Internal Medicine, Infectious Disease, and

Medical Oncology. The Miner was first seen by Dr. Musgrave on August 17, 1998. Dr. Musgrove said the Miner was feeling well from surgery, except for some shortness of breath and a chronic cough. He had quit using tobacco. On physical examination, the Miner's lungs were clear to auscultation. Dr. Musgrave's impression was esophageal cancer, with no suspected underlying residual disease. He did not believe that the Miner would need chemotherapy or radiation. The Miner was given medication for his cough, and instructed to continue using his inhaler.

Dr. King saw the Miner the following day. He planned to get a chest x-ray. The Miner was getting his strength back after his surgery. He was using his inhalers. He was described as a nonsmoker, but a long-term tobacco chewer. COPD was one of nine diagnoses. The Miner was continued on medications and instructed to follow up with his surgeon, Dr. Rogers.

Dr. Rogers and Dr. King next saw the Miner on September 17, 1998. He was still doing well, but had a chronic cough, according to Dr. King. Dr. King said he was not chewing tobacco, and described him as a former tobacco chewer. Dr. Rogers said his lungs were clear.

On October 9, 1998, the Miner went to the emergency room due to right flank pain and vomiting. The impression was right renal stones with colic and hematuria.

Dr. King again saw the Miner for follow-up on October 15, 1998. The Miner reported having had a chest x-ray for evaluation of his pneumoconiosis, resulting in a recommendation for a CT scan, which Dr. King had done, with negative results. The Miner's chest was clear. Dr. King again described the Miner as a former tobacco chewer. COPD was fifth on the list of ten diagnoses, the first being status post esophageal carcinoma.

Dr. Rogers saw the Miner for follow-up to his surgery on April 15, 1999. His lungs were clear. Dr. Rogers noted a small hernia in his abdominal incision, which was referred for repair.

The Miner underwent repair of the hernia, as well as more knee surgery, on April 29, 1999.

The Miner was hospitalized May 29-30, 2001, after increased nausea and vomiting. He was given fluid and medication, and released feeling better. A chest x-ray was taken to follow-up pleural effusion. The results are reported on the table above. Among the discharge diagnoses was recurrent pleural effusion, question whether recurrent disease, cytology pending.

When Dr. King saw the Miner on May 28, 1999, he had had hernia and knee surgery, with good results with both. He was still described as a former tobacco chewer. There is no indication in the records that he ever used tobacco again.

Dr. Musgrave next saw the Miner on July 26, 1999. He reported soreness in his right side and increased heartburn. On examination, his lungs were clear. Dr. Musgrave's impression was esophageal cancer, with no evidence of disease, and gastritis. Dr. Musgrave ordered a CT scan of the Miner's chest, and prescribed additional medication and tests.

The Miner returned to Dr. King on September 28, 1999, and January 31, 2000. He was doing reasonably well. He reported no respiratory symptoms, and his chest was clear on both

occasions. The Miner also saw Dr. Rogers in December 1999 and January 2000, who said he was doing "satisfactory," and that his lungs were clear.

The Miner underwent esophagogastroduodenoscopy with biopsies on February 8, 2000, because of a recent history of weight loss, persistent gastroesophageal reflux, and a history of esophageal carcinoma. A lesion of the stomach suggested either possible inflammation or extrinsic compression, rule out recurrence of esophageal carcinoma and mild esophagitis.

There is an operative report dated April 10, 2000, for laparoscopic cholecystectomy. When he returned to Dr. King on May 31, 2000, Dr. King noted that the Miner had had his gallbladder removed.

On July 12, 2000, a recurrent incisional hernia was repaired.

The Miner was hospitalized from August 1-5, 2000, due to difficulty swallowing and persistent nausea and vomiting. Biopsy revealed that the Miner's cancer had recurred, and he underwent endoscopy to map for radiation therapy, and placement of a MediPort catheter for chemotherapy. Discharge diagnoses were persistent nausea and vomiting secondary to recurrent esophageal carcinoma, history of hypertension, and history of hypovolemia. Dr. Rogers concurred that the Miner should have radiation and chemotherapy. He did not think surgery was an acceptable risk. The Miner's lungs were clear.

When the Miner saw Dr. King on October 3, 2000, he was still undergoing treatment for the recurrence of his cancer. His chest was clear, and there were no reports of respiratory symptoms or shortness of breath.

The Miner saw Dr. Rogers on October 5, 2000. Dr. Rogers reported that he had completed 34 radiation treatments and was swallowing better. He had had two chemotherapy treatments by Dr. Musgrave. His lungs were clear, slightly decreased in the bases. Dr. Rogers said he was stable.

Chest x-rays and a CT scan were taken on November 3, 2000, because the Miner reported being short of breath. The results appear on the tables above.

The Miner underwent another esophagogastroduodenoscopy with gastric biopsy on November 21, 2000, which showed marked response to treatment.

On December 28, 2000, Dr. King reported that the Miner had one more chemotherapy treatment to go.

On January 31, 2001, the Miner underwent another esophagogastroduodenoscopy and evaluation of the status of his cancer. There was no evidence of gross tumor, or evidence of any lesions.

On a visit to Dr. King on March 28, 2001, the Miner was having upper respiratory symptoms with slight wheezing. On examination, there were occasional expiratory wheezes. Of ten diagnoses, COPD was listed fifth.

On April 16, 2001, the Miner underwent diagnostic thoracentesis due to pleural effusion revealed on x-ray. 2200 cc of fluid was obtained and sent for analysis. Post procedure chest x-ray revealed the effusion to be resolved with no other abnormalities noted.

On April 19, 2001, Dr. Rogers reported that the Miner had been breathing better since a right thoracentesis. His lungs were clear, slightly decreased in the bases.

The Miner underwent endoscopy without biopsy on May 1, 2001, for surveillance of his condition. There was no evidence of recurrence, and a large ulcerated area had decreased.

The Miner again underwent thoracentesis on May 24, 2001, for right pleural effusion. Two liters of fluid were removed from his lung.

The Miner was hospitalized beginning June 5, 2001, under the care of Dr. Musgrave, due to increasing shortness of breath. The history noted the Miner's esophageal cancer with suspected lung metastasis, and problems with recurrent pleural effusion and two previous taps. The Miner was very weak and frail. The social history noted past, but not current, tobacco use. He was given oxygen, IV fluids, and medication. Another esophagogastroduodenoscopy with biopsy was performed on June 6, disclosing recurrent tumor cells. CT of the abdomen showed new extensive liver metastases. Thorascopy and biopsy of pleural lesions was performed on June 22. There was no evidence of malignancy in the biopsied material. The consulting surgeon said the most likely etiology for recurrent pleural effusion was recurrent malignancy, or less likely, but possible, the surgical procedure. The Miner was intubated on June 26. By June 28, the Miner was in acute renal failure and ventilator dependent.

The Miner died on July 1, 2001. Dr. Musgrave signed the death certificate. DX 5. The immediate cause of death was esophageal cancer. No underlying or contributing causes were listed.

Opinions Given in Connection with the Claim for Black Lung Benefits

Dr. Musgrave wrote a letter dated September 4, 2001, addressed "To Whom It May Concern" in which he stated:

> [The Miner] was treated for esophageal cancer and black lung disease. He underwent chemotherapy and radiation. The patient developed pleural effusion, increasing his respiratory distress. He basically died in respiratory failure. He was felt to have recurrent tumor but his death was definitely related to respiratory disease. He did have a pleural biopsy, which was negative for tumor. He had a pulmonary function test which revealed restrictive airway disease. If he had not had black lung, he could have potentially handled the pleural effusion and respiratory insults better. We may have been able to stabilize his respiratory status and been able to offer him salvage chemotherapy.

DX 6.

Dr. Fino reviewed the Miner's medical records, including treatment records from 1979 to 2001, the death certificate, Dr. Musgrave's report, and Dr. Wiot's report regarding his reading of

CT scans. Dr. Fino provided a report dated November 3, 2005, summarizing the records he reviewed, and making charts of reported occupational and smoking histories, a December 2000 pulmonary function study, and Dr. Wiot's readings of x-rays taken in August 1998 and June 2001. EX 1. Dr. Fino is Board certified in Internal Medicine and Pulmonary Disease, and a B reader. EX 10. It appears that for the purpose of this report, Dr. Fino relied upon the original CT scan reports, rather than performing his own readings. Thus, he did not rely on inadmissible evidence in forming the opinion expressed in the report. Dr. Fino opined that there was no objective evidence of a coal mine dust-related pulmonary condition. He said that the pulmonary function test was invalid due to poor patient effort. He said the Miner "died directly as a result of metastatic esophageal cancer, which is a disease of the general medical population. There is no increased incidence of this malignancy in coal miners." EX 1 at p. 10.

Dr. David Rosenberg reviewed the Miner's medical records, including the death certificate, Dr. Musgrave's report, Dr. King's records, hospital records, and CAT scans, and provided a report dated November 4, 2005.[5] EX 4. Dr. Rosenberg is Board certified in Internal Medicine, Pulmonary Disease, and Occupational Medicine, and a B reader. EX 5. Dr. Rosenberg summarized the Miner's medical history as follows:

> In SUMMARY, at the time of [the Miner's] death, he was 51 years of age, and he died with metastatic carcinoma of the esophagus. He had over 20 years of coal mining employment, and presented in 1998 with gastrointestinal symptoms and weight loss. Subsequently, he was found to have an extensive esophageal malignancy. Thereafter, an esophageal resection was performed, but he had a recurrence of his malignancy and thereafter, had a downhill course and expired. His X-rays prior to his esophageal carcinoma were clear, without interstitial changes of micronodularity or evidence of CWP. Similarly, after he developed his malignancy his reontgenographic manifestations related in some manner simply to his tumor, without evidence of a dust-related disorder. A review of [the Miner's] serial CAT scans revealed no findings of CWP.

EX 4 at p. 5. Dr. Rosenberg said that CAT scans are more accurate than x-rays in diagnosing the presence of coal workers' pneumoconiosis. He said that looking at all of the evidence together, the Miner did not have the interstitial or clinical form of pneumoconiosis. He said that in the absence of micronodularity, no associated ventilatory impairment would have existed, and from a pulmonary perspective, before developing metastatic cancer, the Miner could have performed his previous coal mining job or similarly arduous labor. He said that esophageal cancer associated with metastasis is an ominous prognosis, and it was not surprising that the Miner had recurrent disease in view of the extensive tumor mass when it was first diagnosed. He said that the Miner's

> … life span would not have been extended in any significant fashion, if he had not had previous coal mine dust exposure. Clearly, [the Miner's] coal mine dust exposure did not hasten his death, and he would have died in a similar fashion, irrespective of his past coal mine employment.

[5] The Employer submitted a report by Dr. Rosenberg dated May 18, 2004, DX 33-18, *et seq.*, when the claim was pending before Judge Solomon. This report was not designated on the Employer's Evidence Summary Form when the case was before me, and has not been considered, as it would exceed the limitations in the rules.

Ibid. He went on to state that the Miner did not have either clinical or legal pneumoconiosis, and no associated impairment from a pulmonary perspective.

Dr. King provided a letter supporting the claim dated November 13, 2005. In his letter, he stated:

> … I had known [the Miner] and had cared for him along with my partner at the time, William T. Fannin, M.D. He did have a diagnosis of black lung and COPD, but subsequently developed esophageal cancer. Dr. Musgrave, the hematologist/ oncologist, continued to care for him until his demise as a result of his lung cancer. However, I do state to you, within a reasonable realm of medical probability and medical certainty, after reviewing the voluminous medical records of [the Miner], that his death was indeed hastened by his restrictive lung disease, which was a result of his occupational exposure and his coal workers' pneumoconiosis. Again, I do concur with Dr. Musgrave's records, in that his death was hastened by his pneumoconiosis.

CX 1.

Dr. Rosenberg was deposed on November 18, 2005. EX 5. Dr. Rosenberg described how he approaches diagnostic examinations by taking histories, conducting physical examinations, interpreting x-rays, and conducting objective testing to measure ventilation and oxygenation, along with the findings necessary to make a diagnosis of coal workers' pneumoconiosis. He said that the disease can cause a restrictive or an irreversible obstructive impairment, which must be correlated with the chest x-ray. He confirmed that he had reviewed the Miner's treatment records. He said that the Miner had a sufficient history of exposure to coal dust to contract pneumoconiosis, as well as a significant smoking history, having smoked a pack a day for most of his adult life. He said the Miner had a medical history of psoriasis, kidney stones, obesity, and hypertension. He reiterated the history of the diagnosis and treatment of the Miner's esophageal cancer he gave in his report. He said that none of the Miner's medical conditions resulted from coal dust exposure. The only pulmonary function tests in the record were performed with incomplete effort, and therefore, could not be used for an accurate assessment of any lung impairment. Based on the Miner's x-rays, Dr. Rosenberg said that more likely than not, the Miner would not have had an impairment. Abnormalities on the Miner's CT scans related to the Miner's cancer, or pleural effusion and infiltrates related to infection or the tumor. There were no findings related to micronodular changes related to coal dust exposure. Dr. Rosenberg reiterated that esophageal cancer caused the Miner's death, which was not in any way related to, caused by, or hastened by coal dust exposure. He disagreed with Dr. King's opinion expressed in the November 13 letter. Dr. Rosenberg said that the Miner's restriction related to pleural fluids and the accumulation around his lung, and the infiltrates related to infection or tumor, and not to coal dust exposure. He said even if the Miner was found to have simple pneumoconiosis, his opinion would not change, because simple pneumoconiosis does not cause restriction. He said that there was no scientific basis to conclude that the Miner's death was hastened by pneumoconiosis. He said it is just not a logical conclusion to think that the Miner would have lived any longer had he not worked in the mines, given the extensive nature of his cancer. He said there was no evidence in the medical records he reviewed that the Miner had legal pneumoconiosis. He said it was unlikely that the Miner's lungs failed earlier than would be

expected from esophageal cancer, because the Miner's respiratory reserve would have been adequate.

Dr. Fino prepared a second report dated November 14, 2005, after reviewing nine CT scans. EX 2. Dr. Fino's CT scan interpretations have not been considered, for the reasons addressed above.

Dr. Fino prepared a supplemental report dated November 18, 2005, after reviewing Dr. King's letter. EX 3. Review of the letter did not cause him to change any of his opinions noted in his earlier reports.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006).

In this case, the Miner's medical records indicate that he was diagnosed with chronic obstructive pulmonary disease, which can be encompassed within the definition of legal

pneumoconiosis. *Ibid*.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003); 65 Fed. Reg. 79938 (2000) ("The Department reiterates … that the revised definition does not alter the former regulations' … requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source.").

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption that a miner's death was due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners who died on or before March 1, 1978); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that an autopsy was performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed her claim after January 1, 1982, and the Miner died after March 1, 1978. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the biopsy, chest x-rays, CT scans, and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at § 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the 31 x-rays taken between 1992 and 2001 available in this case, 4 have been read by one, but not other reviewers to be positive for pneumoconiosis. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2006); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are Board-certified

Radiologists and/or B readers are classified as the most qualified. The qualifications of a certified Radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A Judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

All 31 x-rays in evidence in this claim were taken during medical treatment. None of the Radiologists who interpreted the x-rays for the purpose of treatment made any mention of coal workers' pneumoconiosis. Nor did any mention findings pertaining to obstructive disease. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). Many of the x-rays were characterized as showing a normal chest, clear lungs, or no active disease. I find all of those to be negative. One x-ray in April 1999, and several taken between November 2000 and June 2001 during the Miner's final illness, demonstrated fluid, infiltrates, effusion or, in one case, in April 2001, atelectasis. In view of the absence of any findings more pertinent to the presence of pneumoconiosis, however, I find that these x-rays, too, were negative for pneumoconiosis. Thus, all of the x-ray readings in the "silent" column are negative for pneumoconiosis.

Four of the x-rays were reread by dually qualified Radiologists and B readers. Dr. Alexander found all four to be positive for pneumoconiosis, 1/0, while Dr. Wiot found them to be negative. Dr. Wiot is pre-eminent in the field. *See* his Curriculum Vitae, EX 11. Moreover, there is no support for Dr. Alexander's positive readings to be found in the readings in the "silent" column. Based on Dr. Wiot's superior qualifications, and the fact that I have found all of the other readings of those x-rays to be negative, I find that the overwhelming weight of the x-ray evidence is negative for pneumoconiosis.

Nine CT scans were taken of the Miner's chest between July 1998, when he was diagnosed with esophageal cancer, and April 2001, a few months before his death. Dr. Poulos specifically stated that the July 1998 CT scan showed no parenchymal nodules or pleural abnormalities. None of the other treating Radiologists made any findings indicating the presence of pneumoconiosis or obstructive disease. I also find that all of the CT scans were negative for pneumoconiosis.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented

opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a Judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be given controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2006). The Sixth Circuit has interpreted this rule to mean that …

> … in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2003) (citations omitted). In this case, two of the Miner's treating physicians, Dr. King and Dr. Musgrave, have stated that the Miner had pneumoconiosis. The Employer's experts, Dr. Rosenberg and Dr. Fino, disagree.

All of the physicians who gave opinions did so based on the Miner's treatment records. Dr. King was the Miner's treating physician for about eight years. Dr. King's specialty, if any, is not known. I infer from the records that he is a general practitioner, as he saw the Miner regularly and treated him for a great variety of conditions, occasionally referring him to specialists. The Central Baptist Hospital discharge summary from April 1995, for an overnight hospitalization due to chest pain and severe dyspnea on exertion, contains the first reference to pneumoconiosis in the treatment records; after cardiac catheterization and angiography did not disclose heart disease, the Miner's shortness of breath was thought to be due to his "known pneumoconiosis." However, the hospital record does not state how it was known that the Miner had pneumoconiosis. The diagnosis "COPD vs. CWP" first appears in Dr. King's notes on May 16, 1995. He identified the Miner as a nonsmoker. The record is not conclusive regarding the Miner's tobacco use, but it appears that he was a former smoker, rather than a nonsmoker, and that by the time he was seeing Dr. King on a regular basis, he was chewing tobacco rather than smoking it. In October 1998, when the Miner informed Dr. King about an x-ray apparently taken in connection with the Miner's black lung claim, Dr. King followed up with a CT scan,

which was negative, according to his notes. Although Dr. King treated the Miner for a lung condition with inhalers and other medication, there is nothing in Dr. King's records which gives any indication how Dr. King made the diagnosis of black lung disease, or COPD due to coal dust exposure. Neither the x-ray reports nor the CT scan reports described manifestations of either COPD or CWP; chest examinations were clear until after recurrence of the Miner's cancer in late 2000; and the notes mention only occasional complaints of shortness of breath. Indeed, Dr. King's records are bereft of diagnostic information or functional testing as to the condition of the Miner's lungs, and it appears that the focus of the Miner's office visits was almost always on other problems. As I cannot determine the basis for Dr. King's opinion that the Miner had black lung disease, I cannot give his opinion substantial weight.

Dr. Musgrave's opinion suffers from the same defects as Dr. King's. Dr. Musgrave's office and hospital records indicate that the focus of his treatment of the Miner was esophageal cancer. Although he stated in his letter that the Miner was also treated for black lung, he said nothing about how the diagnosis was made. He referred to a pulmonary function test which revealed restrictive airway disease. However, he did not identify which test he was referring to, and the only pulmonary function test in the record, by Dr. Mettu, has been invalidated by Dr. Rosenberg and Dr. Fino, both of whom, unlike Dr. Musgrave, are Pulmonologists. Dr. Musgrave did not diagnose COPD; as a result, his and Dr. King's diagnoses are inconsistent with each other. As I cannot determine the basis for Dr. Musgrave's opinion that the Miner had black lung disease, I cannot give his opinion substantial weight, either.

Arrayed against the opinions of Drs. King and Musgrave that the Miner had pneumoconiosis are those of Drs. Fino and Rosenberg that he did not have pneumoconiosis. Both are well-qualified Pulmonologists. Both had access to extensive treatment records. Their opinions are well supported by the objective medical evidence of record. Both explained their reasons for concluding that the Miner did not have pneumoconiosis. I find their opinions to be documented and reasoned. Drs. Fino and Rosenberg better explained how all of the evidence they reviewed supported their conclusions. Their opinions are entitled to greater weight than those of Drs. King and Musgrave because they are in better accord both with the evidence underlying their opinions, and the overall weight of the medical evidence in the record as a whole.

Neither the biopsy evidence, the x-ray evidence, the CT scan evidence, nor the medical opinion evidence, weighed separately or together, is sufficient to establish the existence of either clinical or legal pneumoconiosis. Nor has the Claimant shown its presence by any other means. I find that the Claimant has failed to meet her burden of showing that the Miner had a pulmonary or respiratory disease attributable to his exposure to coal mine dust. Thus, she cannot show that pneumoconiosis contributed to the Miner's death, which is required to establish that she is entitled to benefits under the Act.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet her burden to establish that the Miner had pneumoconiosis, or that his death was due to pneumoconiosis within the meaning of the Act and regulations, she is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to her in pursuit of this claim.

ORDER

The claim for benefits filed by the Claimant on September 26, 2001, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's Decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's Decision is filed with the District Director's Office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C., 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C., 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's Decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).